Amendments to the Claims:

1. (Currently Amended) A method for administering health care to patients within a patient population such that utilization of health care resources available to care for said patients within said patient population are conserved, the method comprising the steps:

a) generating said patient population, said generation of said patient population comprising the steps:

i) receiving a request from an individual to become a patient within said patient population;

ii) obtaining information from said individual in step (i), wherein said information is obtained by an in-person interview and wherein said information comprises demographic information related to said individual comprising the individual's age, sex, medical history and geographic vicinity pertaining to said individual's residence as well as the number of emergency room visits, number of hospitalizations and readmissions, patient pharmacy records, and medication compliance, storing such information in electronic medical records embodied on a computer readable medium;

iii) evaluating said data submitted in step (ii);

iv) enrolling said individual as a patient within said patient population; and

v) repeating steps (i) – (iv) for a multiplicity of individuals;

b) receiving a request from a patient within said patient population generated in step a) for medical services;

c) assessing said request made in step b) and determining whether said request substantiates a specified clinical event, wherein said assessment is made by a primary care physician;

d) submitting only a single CPT code corresponding to a single, specified medical service to be rendered in response to the clinical event specified in step (c);

e) evaluating the single code submitted in step (d) for clinical and financial appropriateness, wherein said evaluation is performed by a hospitalist or case manager that is other than the primary care physician, and wherein evaluating the

single code submitted in step (d) comprises (i) evaluating the effectiveness or clinical importance of the service required to be rendered in relation to the code, (ii) evaluating whether the submitted code is applicable to those health care services that are covered by the patient's health care, and (iii) evaluating whether the code is susceptible to duplicative and/or unbundled billing practice or otherwise provides any financial interest to the primary care physician;

f) responding to said submission made in step (d) based upon said evaluation made in step (e), said response comprising either approval or disapproval to proceed with rendering the requested service corresponding to said code submitted in step (d);

g) assessing said request made in step (b) and determining whether said request substantiates the utilization of either in-patient services, out-patient services, referral to a specialist, or combinations thereof, wherein said assessment is made by a primary care physician and the in-patient services, out-patient services and services from the specialist are to be performed by a physician other than the primary care physician;

h) submitting only a single CPT code corresponding to a single, specified medical service to be rendered in response to the utilization requested in step (g);

i) evaluating the single code submitted in step h) for clinical and financial appropriateness, wherein said evaluation is performed by a hospitalist or case manager that is other than the primary care physician, and wherein evaluating the single code submitted in step h) comprises (i) evaluating the effectiveness or clinical importance of the service required to be rendered in relation to the code, (ii) evaluating whether the submitted code is applicable to those health care services that are covered by the patient's health care, and (iii) evaluating whether the code is susceptible to duplicative and/or unbundled billing practice or otherwise provides any financial interest to the primary care physician;

j) responding to said submission made in step (h) based upon said evaluation made in step (i), said response comprising either approval or disapproval to proceed with rendering the requested service corresponding to the code submitted in step (h); and

k) when the patient has a chronic condition, repeating steps (g)-(j) to continuously assess the utilization of the in-patient services, out-patient services, and services of the specialist to provide treatment of the chronic condition.

2. (Cancelled)

3. (Previously Presented) The method of Claim 1 wherein in step (a), substep (iii), said evaluation comprises comparing said information submitted in step (a), substep (ii) with eligibility criteria, said eligibility criteria defining a standard by which said individuals are compared for acceptance as a patient within said patient population.

4. (Previously Presented) The method of Claim 1 wherein step (a), substep (iv), further comprises assigning a risk level to said patient.

5. (Previously Presented) The method of Claim 4 wherein in step (a), substep (iv), said risk level assigned said patient is indicative of the anticipated utilization of resources said patient is projected to utilize while a member of said patient population.

6. (Previously Presented) The method of Claim 3 wherein step (a), substep (iii), further comprises assessing the current state of health of said individual and anticipated future health of said individual by retrospectively examining the individual's prior medical history and prospectively examining the anticipated future medical needs of said individual.

7. (Previously Presented) The method of Claim 5 wherein following step (a), substep (v), such process further comprises step:

(vi) periodically updating and reviewing information indicative of the health of said patients within said patient population and reassigning risk levels associated with said patients within said patient population.

8-10 (Cancelled)

11. (Previously Presented) The method of Claim 1 wherein step (f) further comprises the step of determining whether to provide a reimbursement to said primary care physician for said services sought to be rendered in relation to said code submitted in step (c).

12-13 (Canceled)

14. (Previously Presented) The method of Claim 1 wherein in step (f) said disapproval of said services sought to be rendered in relation to said code submitted in step (c) is followed by the further step:

(a) repeating step (b) – (d).

15. (Cancelled)

16. (Previously Presented) The method of Claim 1 wherein in step (c) said primary care physician is a member of a network of physicians contracted to render medical services on behalf of a health plan, health maintenance organization, or government sponsored health care program.

17. (Previously Presented) The method of Claim 5 wherein step (a), substep (iv) further comprises the step of charging a premium to said individual for becoming a member of said patient population.

18. (Previously Presented) The method of Claim 17 wherein said premium corresponds to said risk level assigned to said patient.

19. (Previously Presented) The method of Claim 1 wherein in step (c), said code corresponds to a single medical service to be rendered exclusively by said physician.

20. (Currently Amended) A method for administering an integrated health care delivery system for providing comprehensive health care to a patients within a patient population such that utilization of health care resources available to care for said patients within said patient population are conserved, the method comprising the steps:

a) generating said patient population, said generation of said patient population comprising the steps:

i) receiving a request from an individual to become a patient within said patient population;

ii) obtaining information from said individual in step (i), wherein said information is obtained by an in-person interview and wherein said information comprises demographic information related to said individual comprising the individual's age, sex, medical history and geographic vicinity pertaining to said individual's residence as well as the number of emergency room visits, number of hospitalizations and readmissions, patient pharmacy

records, and medication compliance, storing such information in electronic medical records embodied on a computer readable medium;

iii) evaluating said data submitted in step (ii);

iv) enrolling said individual as a patient within said patient population; and

v) repeating steps (i) – (iv) for a multiplicity of individuals;

b) receiving a request from a patient within said patient population for medical services;

c) assessing said request made in step b) and determining whether said request substantiates the utilization of either in-patient services, out-patient services, referral to a specialist, or combinations thereof, wherein said assessment is made by a primary care physician;

d) submitting only a single CPT code corresponding to a single, specified medical service to be rendered in response to the utilization requested in step (c);

e) evaluating the single code submitted in step (d) for clinical and financial appropriateness, wherein said evaluation is performed by a hospitalist or case manager that is other than the primary care physician, and wherein evaluating the single code submitted in step (d) comprises (i) evaluating the effectiveness or clinical importance of the service required to be rendered in relation to the code, (ii) evaluating whether the submitted code is applicable to those health care services that are covered by the patient's health care, and (iii) evaluating whether the code is susceptible to duplicative and/or unbundled billing practice or otherwise provides any financial interest to the primary care physician;

f) responding to said submission made in step (d) based upon said evaluation made in step (e), said response comprising either approval or disapproval to proceed with rendering the requested service corresponding to said code submitted in step (c); and

g) when the patient has a chronic condition, repeating steps (c)-(f) to continuously assess the utilization of the in-patient services, out-patient services, and services of the specialist to provide treatment of the chronic condition.

21-25 (Cancelled)

26. (Previously Presented) The method of Claim 24 wherein in step (f) said disapproval of said services sought to be rendered in relation to said code submitted in step (c) is followed by the further step:

(a) repeating step (b) – (d).

27. (Cancelled)

28. (Previously Presented) The method of Claim 20 wherein in step (a) said primary care physician is a member of a network of physicians contracted to render medical services on behalf of a health plan, health maintenance organization, or government sponsored health care program.

29. (Previously Presented) The method of Claim 1 wherein in step (a), substep (ii), said number of emergency room visits and number of hospitalizations and readmissions are determined with respect to the twelve month period preceding obtaining the information.

30. (Previously Presented) The method of Claim 1 wherein step (a), substep (ii) further comprises obtaining information in relation to the current condition of any disease that said individual may have.

31. (Previously Presented) The method of Claim 30 wherein said disease is hypertension.

32. (Previously Presented) The method of Claim 30 wherein said disease is diabetes.

33. (Previously Presented) The method of Claim 7 wherein said reassigning of risk levels is performed every six months.

34. (Cancelled)

35. (Previously Presented) The method of Claim 1 wherein the request for medical services in step (b) is in relation to the treatment of a chronic condition requiring continuous care.

36. (Previously Presented) The method of Claim 35 wherein the chronic condition is selected from the group consisting of diabetes, cancer, and Alzheimer's disease.

37. (Previously Presented) The method of Claim 35 wherein each specified clinical event assessed in step (c) is submitted as a single code every single time the specified clinical event is required until the specified clinical event is no longer required.